NEW YORK STATE DEPARTMENT OF HEALTH
Division of Planning, Policy and Resource Development

New York "State 30" Program Application Cover Sheet

This cover sheet must be completed by all practice sites proposing to employ physicians under the New York "State 30" J-1 Visa waiver program for FFY 2007. Please complete and mail, along with all other requested materials, to: New York State Department of Health, Corning Tower, Room 1084 Albany, New York 12237-0053 (phone: 518- 473-7019).

Please print clearly or type.

I. IDENTIFYING INFORMATION - PHYSICIAN

NAME: Last First Middle Initial

ADDRESS:

City State Zip ☐☐☐☐☐

TELEPHONE: ☐☐☐ ☐☐☐-☐☐☐☐

SPECIALTY:

HOME COUNTRY:

DATE OF BIRTH: ☐☐ ☐☐ ☐☐ (MO DAY YR) USMLE/ECFMG: ☐-☐☐☐-☐☐☐☐-☐

II. ATTORNEY INFORMATION

NAME: Last First Middle Initial

FIRM NAME:

ADDRESS:

City State Zip ☐☐☐☐☐

TELEPHONE: ☐☐☐ ☐☐☐-☐☐☐☐ FAX: ☐☐☐ ☐☐☐-☐☐☐☐

III. PROPOSED PRACTICE SITE INFORMATION

PRACTICE SITE NAME:

SITE CONTACT: Last First

ADDRESS:

City State Zip

TELEPHONE: ☐☐☐ ☐☐☐-☐☐☐☐ FAX: ☐☐☐ ☐☐☐-☐☐☐☐

SPONSORING AGENCY (if different from practice site):

TYPE OF SITE (check one):

- ☐ Hospital
- ☐ Private Practice
- ☐ Hospital Extension Clinic
- ☐ Diagnostic & Treatment Center (Health Clinic)
- ☐ Nursing Home
- ☐ Correctional Facility
- ☐ Other _____

IV. SERVICES TO THE MEDICALLY INDIGENT

The purpose of this section is to determine the amount of services that are, or will be, provided annually to medically indigent patients by the physician listed in Section I at the worksite listed in Section III.

Please estimate the number of patient visits, by source of payment, for the actual physician listed in Section I for the most recent 12-month period for which data is available. Indicate the 12-month period below.

If the physician for whom the waiver is requested is NOT currently employed at the site listed in Section III, please estimate visit data based on visits provided by one currently or recently-employed physician practicing in a similar specialty at the site listed in Section III. **IF THAT IS NOT POSSIBLE, THEN** estimate visits provided by one currently or recently-employed physician practicing in a similar specialty at another similar site.

INCLUDE PATIENT VISITS FOR THE PHYSICIAN ONLY; DO NOT LIST ALL VISITS FOR THE SITE OR FACILITY. Please answer questions 1-3 as accurately and specifically as possible.

Source of Payment	Number of Visits to Physician
1. **MEDICAID** (e.g., Medicaid, Medicaid FFS, Medicaid Managed Care, HMO/PHSP Medicaid, including Family Health Plus):	
2. **SELF-PAY or FREE** (e.g., self-pay, full or partial fee, or Free):	
3. **ALL OTHERS** (e.g., Medicare, Medicare managed care, commercial, other managed care, workers compensation, no-fault, government, Blue Cross/Blue Shield, HMO/PHSP other, including Child Health Plus):	
4. **TOTAL**, 1 + 2 + 3 =	

CHECK ONE:

- ☐ Visit data above refers to services provided by actual physician for which the waiver is requested.
- ☐ Visit data above refers to services provided by another physician in a similar specialty at the site listed in III above.
- ☐ Visit data above refers to services provided by another physician in similar specialty at another, similar site.

12-month period for above data: _____, 200_____.

Source/contact for above data: Name:_____ Telephone: ( )_____

1. Is the physician listed in Section I filling a vacant position at the site? Yes ☐ No ☐
If **yes**, for how long was the position vacant? _____ months.

2. Is the physician proposing to practice at least 40 hours per week in a HPSA or MUA? (**check one**:)

☐ Yes - Indicate the HPSA/MUA/MUP name(s) below. Ignore Section V.

HPSA (s):

_____

MUA/P(s):

_____

☐ No; Go to Section V.

V. PATIENT ORIGIN DATA FOR PHYSICIANS NOT PRACTICING IN HPSAs OR MUA/Ps

The purpose of this section is to collect information on the origin (home residence) of patients whom the physician listed in Section I serves (or is likely to serve) IF the physician DOES NOT propose to practice at least 40 hours per week in a HPSA or MUA.

In the box below, please list the HPSA, MUA or MUP of all patients served by the physician listed in Section I. Use the most recent 12-month period for which data is available. Indicate the 12-month period below.

If the physician for whom the waiver is requested is NOT currently employed at the site listed in Section III, please estimate visit data based on visits provided by <u>one</u> currently or recently-employed physician practicing in a similar specialty at the site listed in Section III. **IF THAT IS NOT POSSIBLE, THEN** estimate visits provided by <u>one</u> currently or recently-employed physician practicing in a similar specialty at another similar site.

In Column 1, list the HPSA, MUA or MUP in which the physician's patients reside. Continue filling out the rows until all patients residing in HPSAs, MUAs or MUPs are accounted for. In column 2, list the 12-month total of visits from all patients in column 1. Provide the subtotals and total as listed below. Add additional pages (formatted as in the table below) as necessary. **COUNT PATIENT VISITS FOR THE <u>PHYSICIAN ONLY</u>; DO NOT LIST ALL VISITS FOR THE SITE OR FACILITY. Please answer all questions as accurately and specifically as possible.**

(1) Name of HPSA, MUA or MUP	**(2) 12-month number of visits from residents in column 1**

1. **Subtotal**, visits from patients residing in HPSAs/MUA/Ps col. 2 total): _____
2. **Subtotal**, visits from patients NOT residing in HPSAs/MUA/Ps: _____
3. **TOTAL, all patient visits provided by physician:** (1 + 2). _____

12-month period for above data: _____, 200_____.

Source/contact for above data: Name:_____ Telephone: ( )_____

CHECK ONE:

☐ Visit data above refers to services provided by actual physician for which the waiver is requested.
☐ Visit data above refers to services provided by another physician in a similar specialty at the site listed in III above.
☐ Visit data above refers to services provided by another physician in similar specialty at another, similar site.